***441—90.3(249A) Authorization and need for service.**

90.3(1) *Authorization required.* Assessment of the need for MR/CMI/DD case management is required at least annually as a condition of payment under the medical assistance program. The department will authorize up to 12 months of service when it has determined that the consumer has a need for service.

a. For applicants who have not received MR/CMI/DD case management within the 12 months before application, the department may include up to 4 prior months in the authorized period for the provider to complete the assessment, intake, and enrollment of the consumer.

b. For applicants who have received MR/CMI/DD case management within the previous 12 months, the provider shall obtain authorization before providing services.

c. For ongoing services, the provider shall obtain authorization before the previous authorization expires.

d. A service authorization may be suspended when a consumer loses eligibility for no more than two consecutive months but is expected to regain eligibility during the two-month period. A consumer who regains eligibility within those two months may resume services for the time remaining under the previous authorization. If the previous authorization expires during the two-month period, the provider shall obtain a new authorization before resuming services.

Payment will not be made for MR/CMI/DD case management provided when the authorization is suspended. MR/CMI/DD case management services will be canceled for consumers who do not regain eligibility by the end of the two-month period.

90.3(2) *Need for service.* The department shall determine the initial and ongoing need for service based on evidence presented by the MR/CMI/DD case management provider, including diagnostic reports, documentation of provision of services, and information supplied by the consumer and other appropriate sources. The evidence shall demonstrate that all of the following criteria are met:

a. The consumer has a need for MR/CMI/DD case management to manage multiple resources pertaining to medical and interrelated social and educational services for the benefit of the consumer.

b. The consumer has functional limitations and lacks the ability to independently access and sustain involvement in necessary services.

c. The consumer is not receiving other paid benefits under the medical assistance program or under a Medicaid managed health care plan that serve the same purpose as MR/CMI/DD case management.

90.3(3) *Managed health care.* For consumers receiving MR/CMI/DD case management under a Medicaid managed health care plan as described in 441—Chapter 88, Division IV, the department delegates authorization and determination of need for service to the managed health care contractor. The managed health care contractor shall authorize services according to the criteria and procedures set forth in this chapter.

90.3(4) *Transition authorization.* In order to ensure that consumers with a need for MR/CMI/DD case management continue to receive service, consumers receiving MR/CMI/DD case management on January 1, 2003, shall be considered authorized for MR/CMI/DD case management for up to 12 consecutive months, beginning with January 2003.

a. During the period of time covered by the transition authorization, the department or, for services under a managed health care plan, the managed health care contractor may implement a determination of the need for service in accordance with subrule 90.3(2).

b. Based on the determination of need, the department or the managed health care contractor may authorize additional months of service or terminate payment.

c. If the outcome of the determination of need results in notice of termination of payment, and the consumer appeals that decision in accordance with rule 441—90.6(249A), then the consumer is entitled to continuation of services in accordance with rule 441—7.9(17A) for the duration of the transition authorization or until the appeal decision becomes final, whichever comes first.